

FINDING OF EMERGENCY

Emergency Regulations Clarifying Plan Responsibilities for Children with California Children's Services Eligible Conditions and Modifying Vision Benefits

As described below, the Legislature has declared that during the 2009-10 and 2010-11 fiscal years the adoption of regulations to modify Healthy Families Program (HFP) health, dental, and vision benefits, and otherwise modify the program requirements and operations, is an emergency. Additionally, the Legislature declared that from March 2, 2011 until June 30, 2012, the adoption of regulations to modify vision benefits is an emergency. At its May 12, 2011 meeting, the Managed Risk Medical Insurance Board (MRMIB) confirmed that the proposed regulations modify HFP program requirements and operations, as they change vision benefits and clarify health, dental, and vision plan responsibilities for children with California Children's Services-eligible conditions. A copy of the Adoption of Emergency Regulations adopted by the Board is attached.

DESCRIPTION OF THE SPECIFIC FACTS SHOWING THE NEED FOR IMMEDIATE ACTION

HFP is California's state- and federally-funded Children's Health Insurance Program (CHIP), established pursuant to Title XXI of the federal Social Security Act. MRMIB administers HFP. HFP provides comprehensive health, dental, and vision insurance to low-income children under age 19 with family income above the Medi-Cal income eligibility levels. (Insurance Code sections 12693 et seq.). Approximately two-thirds of the funding for HFP is provided by the federal CHIP. (42 U.S.C. 1397aa et seq.).

Due to the State's budget crisis, the Governor's 2011-12 Budget proposed eliminating the HFP vision benefits. Elimination of the vision benefit would mean that HFP members would no longer receive early comprehensive vision screening to determine the presence of problems or abnormalities, nor would they receive appropriate glasses, lenses, and/or contacts to correct any identified problems or abnormalities.

In response to the Governor's proposal, the Vision Service Plan (VSP) one of the vision plans participating in the HFP, made a proposal to the Legislature that would:

- Limit the provider network that HFP members could access for vision benefits;
- Reduce the amount and types of benefits for services from non-participating providers; and
- Restrict the number and type of products and materials used for glasses.

These limitations would decrease the per member per month (PMPM) rates of paid to the HFP participating vision plans, thereby generating General Fund changes. The Senate and Assembly Budget Committees reduced VSP's proposal to a bill that passed and was signed by the Governor.

Section 2 of Assembly Bill 97 (Chapter 3, Statutes of 2011) added Insurance Code section 12693.65 to provide that regulations adopted by the Board to implement the new vision benefit and is deemed to be an emergency the Board is exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law:

From March 1, 2011 to June 30, 2012, inclusive, the adoption and readoption, by the board, of regulations to modify vision benefits pursuant to this section, including, but not limited to, restriction of providers through which covered vision benefits may be obtained, restriction of benefits for services from nonparticipating providers, or restriction of products and materials provided as benefits pursuant to this section, shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

The adoption of the proposed regulations would modify vision benefits and, for that reason, are deemed to be an emergency.

These regulations also clarify that HFP participating health, dental and vision plans are responsible to provide care for children with a California Children's Services (CCS) eligible condition until the needed care is authorized and provided by the CCS. This change is needed to be consistent with Insurance Code section 12693.62, and is deemed to address an emergency as a benefits modification in fiscal year 2010-11.

Section 3 of Assembly Bill 1422 (Chapter 157, Statutes of 2009) amended the HFP statutes (Insurance Code sections 12693 et seq.) to modify program requirements and operations. Section 2 of AB 1422 added Insurance Code section 12693.22 to provide that the adoption of regulations for that purpose is deemed to address an emergency for purposes of sections 11346.1 and 11349.6 of the Government Code:

During the 2009-10 and 2010-11 fiscal years, the adoption and readoption of regulations to modify health, dental, and vision benefits or otherwise modify program requirements and operations consistent with the provisions of this part shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

The adoption of the proposed regulations would modify program requirements and operations and, for that reason, are deemed to be an emergency.

AUTHORITY AND REFERENCE CITATIONS

Authority: Sections 12693.21, 12693.22, and 12693.65, Insurance Code.

Reference: Sections 12693.02, 12693.03, 12693.04, 12693.09, 12693.10, 12693.11, 12693.12, 12693.14, 12693.21, 12693.22, 12693.62, 12693.64, 12693.65, 12693.66, Insurance Code.

INFORMATIVE DIGEST AND POLICY STATEMENT OVERVIEW

Policy Statement: The objectives of the proposed regulation changes are to (1) clarify that participating health, dental, and vision plans are responsible for providing care for children with a CCS-eligible condition until the needed care is authorized and provided by CCS, and (2) modify vision benefits and member share of cost in accordance with legislative direction.

Existing Law: Current statutes provide that MRMIB shall establish specific benefits and coverage that meet federal requirements. (See Insurance Code sections 12693(g), 12693.21(h).) Specific benefits are set forth in HFP regulations to which MRMIB proposes amendments, cited below. In addition, current statutes provide for MRMIB to contract with plans for coverage. (See Insurance Code section 12693.21(f).) The statutes also address coordination of services for children who may have a CCS eligible condition. (See Insurance Code sections 12693.62, 12693.64, 12693.66.)

A summary of the proposed regulations' effect on existing law and regulations is as follows:

2699.6700 Scope of Health Benefits

Section 2699.6700 explains the basic required and optional benefits health plans must provide to HFP members.

Section 2699.6700(a)(23)(A) would reformat existing language into a sub-section and move some language into subsection (C), but it would make no substantive changes.

Section 2699.6700(a)(23)(B) would add language to clarify that participating health plans are excused from responsibility for providing a covered service to treat a subscriber's CCS condition only to the extent a CCS provider is authorized to provide and actually provides the service under the CCS program.

Section 2699.6700(a)(23)(C) would reformat existing language from subsection (A) into a new sub-section, but it would make no substantive changes.

2699.6709 Scope of Dental Benefits for Subscriber Children

Section 2699.6709 sets forth the basic required and optional benefits dental plans must provide to HFP members.

Section 2699.6709(a)(11)(A) would reformat existing language into a subsection and would move some language into subsection (C), but it would make no substantive changes.

Section 2699.6709(a)(11)(B) would add language to clarify that participating dental plans are excused from responsibility for providing a covered service to treat a subscriber's CCS condition only to the extent a CCS provider is authorized to provide and actually provides the service under the CCS program.

Section 2699.6709(a)(11)(C) would reformat existing language from subsection (A) into a subsection, but it would make no substantive changes.

Section 2699.6721 Scope of Vision Benefits

Section 2699.6721 sets forth the basic required and optional benefits vision plans must provide to HFP members.

Section 2699.6721(a)(3)(B) would be amended to reduce the maximum benefit allowance for contact lens examinations, fittings, and lenses from one hundred and ten dollars (\$110.00) to one hundred dollars (\$100.00).

Section 2699.6721(a)(5)(A) would reformat existing language into a subsection and would move some language into subsection (C), but it would make no substantive changes.

Section 2699.6721(a)(5)(B) would add language to clarify that participating vision plans are excused from responsibility for providing a covered service to treat a subscriber's CCS condition only to the extent a CCS provider is authorized to provide and actually provides the service under the CCS program.

Section 2699.6721(a)(5)(C) would reformat existing language from subsection (A) into a subsection, but it would make no substantive changes.

Section 2699.6725 Share of Cost for Vision Benefits

Section 2699.6725 explains HFP members' share of cost for various vision benefits.

Section 2699.6725(a)(2) would reduce the frame allowance for services within the vision plan's panel of approved providers from seventy-five dollars (\$75.00) to thirty-five dollars (\$35.00) and would require participating vision plans to ensure that a selection of frames that do not cost more than the frame allowance be available to all subscribers.

Section 2699.6725(a)(4) would reduce the allowance for contact lens examinations, fittings, and lenses from within the vision plan's panel of approved providers from one hundred and ten dollars (\$110.00) to one hundred dollars (\$100.00).

Section 2699.6725(b)(2)(A) would reduce the reimbursement rate for single vision lenses from providers not included in the vision plan's panel of approved providers from up to twelve dollars and fifty cents (\$12.50) to up to seven dollars and fifty cents (\$7.50) for one single vision lens or from up to twenty-five dollars (\$25.00) to up to fifteen dollars (\$15.00) for a pair of single vision lenses.

Section 2699.6725(b)(2)(B) would reduce the reimbursement rate for bifocal lenses from providers not included in the vision plan's panel of approved providers from up to twenty dollars (\$20.00) to up to fifteen dollars (\$15.00) for each bifocal lens or from up to forty dollars (\$40.00) to up to thirty dollars (\$30.00) for each pair of bifocal lenses.

Section 2699.6725(b)(2)(C) would reduce the reimbursement rate for trifocal lenses from providers not included in the vision plan's panel of approved providers from up to twenty-five dollars (\$25.00) to up to twenty dollars (\$20.00) for each trifocal lens or from up to fifty dollars (\$50.00) to up to forty dollars (\$40.00) for each pair of trifocal lenses.

Section 2699.6725(b)(2)(D) would reduce the reimbursement rate for lenticular lenses from providers not included in the vision plan's panel of approved providers from up to fifty dollars (\$50.00) to up to forty-five dollars (\$45.00) for each lenticular lens or from up to one hundred dollars (\$100.00) to up to ninety dollars (\$90.00) for each pair of lenticular lenses.

Section 2699.6725(b)(2)(E) would reduce the reimbursement rate for frames from providers not included in the vision plan's panel of approved providers from up to forty dollars (\$40.00) to up to twenty-five dollars (\$25.00).

Section 2699.6725(b)(2)(I) would reduce the reimbursement rate for elective contact lenses from providers not included in the vision plan's panel of approved providers from up to one hundred and ten dollars (\$110.00) to up to one hundred dollars (\$100.00).

TECHNICAL, THEORETICAL, AND EMPIRICAL STUDY or REPORT

None

DETERMINATIONS

The Proposed Substantial differentiation from existing comparable Federal Regulation or Statute: None

Mandates on Local Agencies or School Districts: None

Mandate Requires State Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None

Costs to Any Local Agency or School District that Requires Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: There are no costs to local agencies or school districts that would requirement reimbursement.

Costs or Savings to Any State Agency: The State will realize a General Fund savings of \$3.25 million in fiscal year 2011-12 and \$3.65 million for the two subsequent fiscal years due to benefit changes.

Costs or Savings in Federal Funding to the State: The Federal government will realize a savings of \$6.04 million in fiscal year 2011-12 and \$6.59 million for the two subsequent fiscal years due to benefit changes.

Costs or Savings to Individuals or Businesses: This will limit the HFP provider network, reduce the amount and types of benefits for non-participating providers, and restrict the number and type of products and materials used for glasses by the HFP members. There are potential costs to HFP members, vision plans and providers.